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THE BULLETIN

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Psychotherapy of Diseases of Women

BY PALMER FINDLEY, OMAHA, NEBRASKA

Psychic treatment, or, as it is popularly termed, suggestive treatment, is of the utmost importance in the management of gynecological cases. It is to be regretted that this subject receives so little consideration in practice and that it is almost wholly ignored by authors of text-books. No gynecologist will fail to appreciate the great need of a system of therapy that will be effective in the great class of neurotic diseases so common among women. Such cases are the despair of gynecologists, and for no good reason were they intelligently managed.

No attempt will be made to classify the neuroses. In this brief chapter reference will be made only to the psychoneuroses, a term indicative of the functional, psychic nature of the disorder, for the relief of which psychotherapy is directed. *"Nervousness is a disease preeminently psychic, and a psychic disease needs psychic treatment."*

Physicians are too prone to insist upon a pathological basis for all disease, and to fail to recognize the existence of purely psychic disorders which have no organic basis, and which are psychic in origin. This fact is preeminently true of the gynecologist who insists upon locating the exciting cause of nervous manifestations in the uterus and ovaries. Happily this is not true today in the

sense that it was at the time of Emmet and Battey, who saw in erosions and lacerations of the cervix and in minor lesions of the ovaries the incentive for all sorts of neuroses.

The fact that the psychoses occur most frequently in women, and that they are especially prone to arise at puberty, the menstrual periods, during pregnancy, in the puerperium, and at the menopause has given rise to the popular impression that the genital organs are responsible. From the middle ages came the statement that "the most frequent causes of hysteria are the deprivations of the privileges of love, the vexations in connection with this passion, and the derangements of menstruation." The same idea is still found in the expression, "She will be all right after she is married." Doctors are preeminently materialistic, and this tendency finds its expression in the demand for an organic basis for all nervous manifestations. There is too little appreciation of the prevalence of disease that has no organic basis, that is purely psychic in foundation and must needs be met by psychic influences. In his determination to find a pathological basis for the nervous manifestations of his patient, the physician finds a stenosed cervix, a lacerated or eroded cervix, a displaced uterus or tender ovaries, and there he halts, content to look no further for the cause of the nervous phenomena. He is fully convinced that the headaches, the insomnia, the hysterical seizures, and the countless vague and fleeting pains about the body are the direct result of the pelvic lesions which he has discovered, notwithstanding the fact that many women who regard themselves healthy possess these selfsame lesions. He has failed to recognize the psychic element in his case, and failing in this he is in no position to apply effective treatment.

No physician is so wise in his own experience, nor so learned in the theory of medicine but he may mistake psychoneuroses for bodily disease. Practically all the clinical syndromes which characterize bodily ailments have their counterpart in nervousness. And hence it follows that complaints referable to one or another of the pelvic organs call for local treatment or operative procedures thru failure to recognize their psychic nature. Psychoneuroses are not secondary to functional and organic disorders, but are primary. Dubois believes that all psychoneuroses are congenital, that some of them are brought to light suddenly by

overwork, anxiety, trauma, or slowly by the development of organic lesions and the gradual undermining of the general health. Many neurotic individuals will trace their nervousness to a certain date, prior to which they were "perfectly well," but by close questioning it will be found that in every case there are mental stigmata of neuroses dating back to their earliest childhood; as a child the patient suffered from insomnia, was sensitive to various impressions, she suffered from functional disturbances of the digestive organs. In later years there was a lack of mental poise, the intelligence was fragmentary, she developed into a neurasthenic, a hystero-neurasthenic, a hypochondriac, an alien. This progressive degeneracy can be traced in families thru generations and in individuals at various times of life.

Neurasthenia is the mildest type of psychoneuroses and may be the forerunner of all other forms, even of insanity. A tendency to exhaustion characterizes the neurasthenic. There is an element of irritability in the exhaustion, hence the expression "irritable weakness." In things physical, mental, and moral they are weaklings. Their muscular development may be strong and their blood of good quality, yet they suffer fatigue from the slightest exertion. The frequent coexistence of neurasthenia and pelvic disorders has led to the hasty conclusion that the former is the result of the latter, when as a matter of fact there may be no connection between the two conditions, or at most the unstable mental equilibrium, with its tendencies to exaggeration and to autosuggestions, serves to aggravate these pelvic complaints. The discomfort that is common to the menstrual period is exaggerated into pain so severe as to cause the patient to take to her bed. The individual is harassed by headache, backache, digestive disorders, transitory pains, and all manner of menstrual disorders. Such patients court the sympathy of their friends, and their multitudinous ailments thrive upon it.

Pelvic lesions, which in well-poised individuals would pass unnoticed, are in such individuals the source of much suffering and the incentive for no end of complaint. A movable, slightly retroposed uterus is the occasion for backache; a subinvoluted uterus causes feelings of weight and pressure in the pelvis; cystic ovaries are tender to the touch and the focus of menstrual pain. These lesions may have existed for years and without the knowl-

edge of the patient, but when neurasthenia developed with its characteristic weaknesses, its disposition to exaggerate and to suggest, then it is that the patient makes her demands upon the gynecologist, when as a matter of fact she rightfully belongs to the neurologist. Untold harm is done by the physician who examines her, who finds these lesions, calls her attention to them, and tells her that they are the source of her nervousness and her weakness. She broods over her assumed troubles, the neurasthenia deepens, it develops into hysteria, melancholia, and perchance insanity. The necessity for clinical experience, wisdom, and discretion in the treatment of neuropaths is self-evident, to the end that functional disorders and the mentality of the individual may be duly appreciated in their bearings upon organic diseases.

Hysteria manifests all the elements of fatigue, emotion, and sensitiveness found in neurasthenia and to an exaggerated degree. In addition to all these elements is the dominating one of autosuggestibility. Passionate outbursts find their expression in convulsive movements simulating epilepsy, catalepsy, or chorea, and are engendered by fear, spite, and anger. A semicomatose state in which the patient lies perfectly inert, with the eyes convulsively closed and the jaws clinched, is their expression of wounded feelings; they are sulking. They become ill or are injured, their ailments create fears and phobias which become more and more exaggerated, new ones are created until the hysteria may deepen into melancholia and the melancholia end in insanity. Their physical ills are exaggerated by their disordered mentality, and the disorders of the mind multiply their physical ills, and thus the vicious cycle is established in which the neuroses travel.

Melancholia borders very closely upon insanity, and we find the patient fearful of impending disaster. She broods over the ills to come and borrows all manner of troubles. Unlike hysteria, melancholia manifests fixed ideas, the reasoning is logical but is based upon false premises. As the disorder deepens we see in them elements of insanity. They are troubled with hallucinations, become delirious, and at times may manifest suicidal tendencies. According to Dubois the pathognomonic characters of this condition are "the feelings of heaviness, fatigue, and inertia; the patients are unconscious of moral and physical depression," there is

"a physical and moral helplessness." Dyspepsia, constipation, and insomnia have been termed the trio of functional neuroses of the psychoneuroses. It is rare that a nervous patient is free from digestive disorders, such as anorexia, nausea, vomiting, flatulency, eructations of gas, diarrhea, and constipation. As manifestations of an unstable nervous equilibrium they are amenable to psychotherapy. Dubois is of the opinion that ninety per cent of dyspeptics are psychoneurotics, and that such patients should have nothing to do with restricted diet and stomachic medication. Such a statement will be looked upon as extravagant, and yet it affords much food for reflection. The functions of the urinary organs are not infrequently disturbed in psychoneurotics. There may be polyuria, oliguria, incontinence of urine, and the bladder and kidneys may be the seat of painful sensations. All these conditions may be, and often are, of psychic origin and amenable to suggestive treatment.

A multitude of sexual aberrations belong strictly to the field of psychiatry, such as sodomy, tribadism, onanism, and masochism. These cases are very unsatisfactory to treat because of their moral depravity. The onanism practiced in childhood may persist to adult life as a fixed habit. In childhood the habit is almost universal and seldom does harm; in adult life there are possibilities of grave consequences. What may be regarded as a normal exercise of the sexual functions becomes libertinism. The fatigue which results from such excesses engenders an unstable mentality. While moderate exercise of the sexual functions may exert a calming effect upon the nervous system, sexual excesses exhaust the nervous force. Regular exercise of the sexual functions appears to exert a beneficial effect upon the general health. It is a significant fact that the psychoneuroses are more often found in the unmarried.

Menstruation has a very decided influence upon the mentality. During the menstrual period women are more sensitive to impressions and autosuggestions; headaches, despondency, and general fatigue are experienced, and hence it follows that at this time all sorts of psychic phenomena arise in those not endowed with a stable mentality. The normal woman may be regarded as a psychoneurotic during the menstrual period. Thruout pregnancy and the puerperium these conditions exist, but to an exag-

gerated degree, by virtue of their long duration. So with the menopause, which may be termed the fretful period of life, a time when the ordinary events of life disturb the mental equipoise.

In the *treatment* of the psychoneuroses two problems are before us: We are primarily concerned with the existing troubles and endeavor to remove them; secondly, we direct the patient's habits of life in a manner that will tend to prevent the recurrence of these troubles. First of all it is imperative to consider the symptom complex rather than to deal with each individual symptom as a problem in itself and bearing no relation to the other clinical manifestations. It must be clearly impressed upon the physician in charge that the factor which underlies all the clinical phenomena is the *disordered mentality,* and hence it follows that it is the mind and not the individual organs that demands consideration. We not infrequently effect cures of psychoneurotic diseases by operative and medicinal measures directed to the individual organs which are not diseased, but which are functionally deranged thru the influences of the morbid mind. The cure in such instances is the result of suggestion. How much better to obtain the same result by the more rational means of acquainting the patient with the nature of her trouble so that by the exercise of her own will power she may find relief without medicine and without surgery. Psychic treatment is often combined with medical and surgical treatment, and it may be to the detriment of the patient, in that the patient is encouraged to feel that she really is sick in body rather than in mind. Dubois makes this sweeping statement: "The nervous patient is on the path to recovery as soon as he believes he is going to be cured; he is cured on the day that he believes himself to be cured." Dubois further affirms that "it is essential, not only that the patient should be convinced of this, but that the physician himself should be convinced in order that he may convey conviction to his patients by the contagion which conviction engenders." With this conviction possessing the physician, it matters little what means he undertakes to obtain his results so long as he gets the results, and herein lies the success of charlatans, religious fanatics, medicine, surgery, and psychotherapy in the treatment of psychoneurotic diseases.

Rational psychotherapy is to be directed along educational lines; it is an appeal to the mind and to the reason; the patient is

encouraged to exercise her judgment and her good sense in combatting her nervousness. If the physician is not self-possessed he can not control his patients; if he is timid he can not embolden his patient; if he is indifferent his patient will fail to be influenced by him; if he is indecisive his patient will be slow in coming to a conviction. A bond of sympathy must exist between the physician and the patient, but not that sympathy which would encourage invalidism. In the making of the diagnosis organic lesions are first eliminated before the diagnosis of psychosis is established, and when once established the physician proceeds with perfect confidence to instruct his patient, to encourage her by words of sympathy and counsel, and to lead her out of her troubles by appeals to her reason and to her self-will. Thus is engendered the expectancy of cure, and the patient is well along on the way to recovery. It is seldom wise to admit to the patient the possible presence of a concomitant affection, lest she fail to be convinced that she can recover from a malady that to her is as real as the one demanding surgical or medicinal treatment or which has been pronounced incurable. The mentality of every patient is a law unto itself and must be studied from day to day in order that results may follow. A single interview may effect a cure in some instances, but such cases are exceptional. Certain physical means of treatment are demanded in the majority of cases, and by physical means is meant a combination of rest in bed, overfeeding, and isolation as advised by Weir Mitchell.

The great problem in the management of such cases is to judiciously employ the moral and the physical means in right measure. Where the quality of the blood is below the normal standard, the general nourishment of the body poor, and the environment and habits of life such as to drag the patient down, rest in bed, isolation, and overfeeding are absolutely essential to recovery. I would go still further and say that where there is a pelvic lesion, that in itself demands correction. Because of the discomfort it creates this should not be neglected. Indeed a lesion in a nervous individual may demand medicinal and operative treatment when the same lesion in a woman of sound and well-balanced mentality would give rise to little or no discomfort and therefore would not call for treatment. Here is the parting of the ways of conservative gynecologists and neurologists; the for-

mer will not ignore a pelvic lesion when found in a nervous individual, but will deal with it on its own merits, while the latter are inclined to attach all importance to the psychic element and none to the pelvic lesion unless it is exceptionally grave. The patient must not be made to fit the rule, but the rule should be made to fit the patient. Prolonged rest in bed and overfeeding are indicated in all cases where fatigue and malnutrition predominate. Energy is stored up in all the organs of the body temporarily at the expense of the muscular force. The appetite, the digestion, and the circulation will usually be favored to the end that the patient proceeds to mental and bodily health.

Where the patient frets under the restraint of isolation and inactivity, some little occupation such as needlework and light reading should be permitted. When dyspeptic symptoms are purely of nervous origin, forced feeding should be aggressively pursued. Where the dyspeptic symptoms are deep-rooted, a preparatory milk diet may precede that of solid foods.

The complaints of the patient may be encouraged by sympathetic friends, hence isolation is of the utmost importance. On the other hand, homesickness is a serious barrier to recovery, and should be guarded against by giving encouragement that recovery will soon follow.

General massage is helpful in that it provides for passive gymnastics without the expenditure of nervous energy, and it aids in reconciling the patient to her enforced isolation and inactivity.

Diagnosis of Skin Diseases

BY ALFRED SCHALEK, OMAHA, NEBRASKA

Until the middle of the last century every skin disease was considered a symptom of an internal disorder either of the blood or some organ. The treatment was accordingly principally constitutional, and local applications received scant attention only. The first step towards eliminating this mistaken idea was the discovery of the itch mite, the favus fungus, and later the trichophyton parasite as the cause of some eruptions. The progress in bacteriology gave further impetus to the emancipation from the theories of different diatheses. Erysipelas, furunculosis, actinomycosis, leprosy, blastomycosis, and others are now known to be due to specific organisms. A number of eruptions, however, still belong to the symptomatic class, and the treatment of the underlying cause is the principal indication there. So, for example, the acute infections, as scarlatina, variola, specific diseases like syphilis, vasomotor disturbances like urticaria and pruritus, and diabetic gangrene. In the great majority external applications must be our main standby, tho in order to get results from them, the knowledge of the different remedies and their effect on the tissues is not sufficient. The diagnosis is of the greatest importance, and without it mild self-limited eruptions are likely to be exaggerated, or, which is worse, the seriousness of others be overlooked, to the detriment of the patient. To treat a case symptomatically, without knowing its nature, is like sailing the deep sea without a compass. Unfortunately, the matter of diagnosis in dermatology seems to be the bugbear of the general practitioner. Many do not even go to the trouble of trying to make an accurate diagnosis, relieving their conscience by calling this task too difficult and complicated. Yet by acquiring the habit of careful observation of all details and using a sound judgment they could overcome the imagined difficulties in the majority of cases. Skin diseases, which are exceptionally puzzling on account of their rarity or complications, may be left to men who make a special study of this field. To arrive at a correct diagnosis, certain rules should be followed methodically. First of all, the past and present

state of the health of the patient, hereditary tendencies in his family, his age, occupation, and habits should be ascertained. In women the condition of the menstrual function, and if married any abortions and miscarriages in the order of their occurrence. In the male the history of previous venereal diseases should be inquired into. Habits are predisposing factors of certain diseases: the effect of excessive use of spirits or of tea is well known, tho it would be an injustice to many patients with rosacea to trace it always to such a cause. A suddenly appearing generalized exacerbation of an already existing dermatosis is not always its manifestation, but may have been produced by some indiscreetly employed external or internal medication. The symmetry and rapidity of such outbreaks should always direct suspicion to such possibilities. The age of the patient speaks at once for or against some skin affections which are found exclusively or preferably at certain periods of life. Epitheliomata and keratosis senilis are seen in advanced life; pustular eczema of the face and scalp, impetigo contagiosa are common in children; acne vulgaris during puberty; sycosis, trade eczema, rosacea in adults. Poverty, with consequent lack of hygiene, and ignorance are responsible for many cases of pus infections, parasitic diseases, and late manifestations of syphilis. The occupation sometimes offers clues to a diagnosis. People who continually handle irritating materials of mechanical or chemical nature consult the physician for eczema of the hands; workers in sugar refineries suffer from furunculosis, butchers from tuberculous warts, cattlemen from ringworm. The history of the duration of the eruption is another determining factor in making the diagnosis. Many skin diseases are essentially chronic, others more or less acute. The duration of existence may decide between a dermatitis or impetigo and eczema. Dermatitis disappears shortly after the cessation of the cause, impetigo gets well under simple antiseptic dressings, but eczema persists under the best conditions for some time. There are even considerable gradations in the chronicity itself, as, for example, between lupus vulgaris and syphilis.

After all these preliminaries, a thoro examination of the whole body is in order. Never be satisfied with the description volunteered by the patient or inspect such portions only as he may show you. The reluctance to uncover completely may be due to

the wish to save inconvenience or else to the ignorance of other existing patches. The whole extent of the disease must be seen and known, because frequently the small visible areas are atypical and may cause errors in the diagnosis. In the case of women a little delicacy will overcome any objection to such apparently unnecessary exposure. By following this rule, scaliness of the scalp may occasionally prove to be psoriasis when other typical patches are found on the extensor surfaces or to be seborrhea if the sternum is affected. A few papules on the face may look innocent until some hidden-away, flat condylomata furnish additional evidence of the presence of syphilis. Bright daylight is essential for the inspection, because the characteristic color or shape of the lesions may not otherwise be recognized. The temperature of the room should be warm; some erythemata disappear if the skin is suddenly chilled by the contact with cold air; others, like the macular syphiloderm, become accentuated. Furthermore, a mottling caused by superficial congestion may confuse the whole appearance.

The objective symptoms of the skin diseases are of the highest importance and often sufficient in themselves to lead to the diagnosis without further questioning. The cutaneous lesions are called primary if appearing in their typical form from the start, and are the macules, papules, vesicles, tubercles, and bullae; pustules belong either to this class or to the one mentioned next. Frequently these lesions lose their typical original form and are transformed into the consecutive lesions: scales, crusts, ulcers, scars, and others. If they coalesce and form patches they may not be identified by the novice who looks for the well-known landmarks, but as a rule some can be found in their typical form around the borders where the disease is still progressing. It is easy and well worth while to be thoroly informed about all the primary lesions and their characteristics, as they are few in number and only by undergoing different changes form the multitude of all skin diseases. Thru the evidence we can easily narrow down the consideration of differential diagnosis. For example, if the patient presents papular lesions, herpes, pemphigus, and others can be excluded at once. Uniformity and multiformity are other identifying features. Lichens planus, and psoriasis present the same lesions thru their whole course, while polymor-

phism is always evident in syphilis or eczema. Besides this, it is on account of some peculiar feature or combination of features of the cutaneous efflorescences that the individuality of some eruptions is established. The color, depth, outlines, configuration, and distribution are some of the contributory facts to be noted. The color is often a valuable guide. The copper red of some syphilitic manifestations is usually the first thing which impresses itself on the mind of the student. The straw-color of impetigo, the sulphur yellow of favus, and the coffee-brown of tinea versicolor are characteristic. Of deciding diagnostic value are the shiny scales of psoriasis with the mother-of-pearl luster, and the dark green oyster shell-like crusts of syphilitic rupia. It should always be the rule to remove some of the scales or crusts in order to see the appearance of the tissues underneath. In lupus erythematosus the scales have stalactite prolongations into the sebaceous ducts, in psoriasis slight punctate hemorrhages are seen; the crusts of impetigo cover superficial reddish erosions, and those of syphilis round ulcers with clean-cut edges and purulent floors. This character of such ulcers is in itself distinguishing from those of carcinoma with elevated waxy edges or the soft undermined tuberculous ulcerations, two affections from which they must often be differentiated. The depth of a skin affection is directly related to its gravity. Superficial lesions are usually short-lived, while deep changes are followed by more or less destruction, formation of scars, and loss of function. Infiltration, a frequent sign of chronicity, is determined by pinching a fold of the skin between the fingers. The outlines of a dermatosis give further pointers towards the diagnosis. In eczema and dermatitis the borders of the patches are indefinite, gradually fading into normal skin, while in erysipelas and psoriasis they are sharply defined. Skin diseases in which the outlines appear in circles, or coalescing segments of circles, probably belong to the parasitic class of ringworm, favus, and others. Even where the microorganisms are not yet known, as in seborrhoic dermatitis and psoriasis, such etiology is strongly suspected for this reason. The dryness or moisture of the affected area will admit or exclude certain diseases. Oiliness points to seborrhea or to hypersecretion of the sweat glands; psoriasis is always a dry disease; while exudation is common in eczema. In alopecia the aspect of the af-

fected hair and of the scalp point decidedly to the right diagnosis. An uneven breaking off and patchy falling out of the hair is produced by syphilis, a perfectly circular bald area with a smooth surface is alopecia areata a symmetrical baldness with an oily scalp, seborrhea. In trichophytosis the edges where the disease progresses will still show vesicles and pustules, the center being covered with black dots, representing the ends of broken-off hair. In favus, ulcerations, scars, yellow cup-shaped crusts, and a peculiar mouse odor will not permit a mistake.

The location and the distribution are of importance from a diagnostic standpoint. Eruptions which are due to external causes like dermatitis, venenata resulting from chemicals or poisonous plants, and impetigo due to staphylococcus infection, naturally appear most commonly on the exposed parts of the body. Skin diseases limited to the hands and other easily accessible parts point to such etiology. An eruption limited sharply to one side of the body is probably due to a central affection of the nervous system and is probably herpes zoster or a naevus unilateralis. The extensor surfaces, especially the knees, elbows, and the sacrum, are preferably occupied by psoriasis, the flexor sides by lichen planus and intertrigo. The face is the favorite seat of acne, the nose and adjacent parts of rosacea. If the eruption is distributed symmetrically over both sides of the body, an external irritation may be excluded as the cause, as this could have hardly affected the skin in such an even way; if found on covered parts only, it is probably caused by some parasites which depend on protection and higher temperature.

Aside from the manifestations which can be observed with the eyes, the subjective complaints of the patient must be taken into consideration. They consist of burning, itching, tingling, and pain. Pain is encountered in burns, carbuncles, and deep ulcerations; neuralgic pain is pathognomic of herpes zoster. Itching is particularly troublesome in eczema, pediculosis, and scabies. An absence of subjective symptoms in spite of formidable cutaneous lesions is suspicious of syphilis.

Last but not least the microscope must be mentioned as a diagnostic help. As to the presence of different parasites, like those of trichophytosis, actinomycosis, and blastomycosis, and in the examination of tissues of malignant growth and of tuberculosis, its evidence must give the deciding verdict.

Some Suggestions Concerning the Making and Closing of Wounds

BY BYRON B. DAVIS, OMAHA, NEBRASKA

The chief object of an operation is to do away with the pathological condition for which the patient seeks relief. The supreme test of surgical skill is measured by one's ability to save life and relieve suffering. The immediate result aimed at may be reached through a very ragged incision. If the life is saved and the urgent symptoms mitigated the operation is pronounced a success.

It is the purpose of this little paper to touch upon a phase of surgical activity that has been given scant attention. If, after a so-called successful operation, there is left an ugly, unsightly, and irritable scar, a constant reminder of former trouble, it is a reproach to the surgeon, and likely to be regarded very much as a poorly adjusted fractured bone. In each case the patient is alive and functionally may be about normal, but he broods over his condition, and the first gratitude towards his doctor may change to criticism.

If during the operation muscles have been cut and have repaired imperfectly, so that their function is not quite smooth and normal, or if important nerves have been divided, leaving paralysis, in whole or in part, of the muscles supplied by them, it is only a question of time before the patient may cease to be wholly loyal, or at least to admit to himself that his surgeon has not been found as perfect as had been thought, perhaps to question if it would not have been better to have employed Dr. X.

I am convinced that the time is coming when patients will demand of the surgeon they employ more attention to the little niceties of his work—something that has been too little cultivated. People are getting accustomed to being snatched from the brink of the grave by brilliant operations, and are beginning to demand that it be done artistically. With these rather prolix introductory remarks you are surely ready to admit that the writer, at least, is impressed with the importance of his subject.

My remarks have little to do with a case where an infection is already present and drainage required. Under such conditions the wound is of secondary importance, for here the saving of life

and cure of the pathology are paramount, and the more strictly esthetic considerations must not be allowed to jeopardize the greater interests. The saving of life here ranks as a necessity, while a good-looking wound is only a luxury. But it must be remembered that people are always ready to pay more for luxuries than for necessities.

Even when operating to remove infections, if possible to make the wound so that the resulting scar will be as unobtrusive as practicable, the average patient will appreciate it. Sometimes it can be so placed as to be concealed by the clothing, or the direction of the incision can correspond to the natural skin creases and the scar thus be made inconspicuous. Professor Schede, when I was in Hamburg, made a practice of excising unsightly scars resulting from drainage wounds, and suturing them neatly before considering the patient ready to discharge from the hospital. This is probably impracticable as a regular custom, but there are frequent cases where such a procedure would be greatly appreciated.

There is one class of incisions towards which it is especially desired to direct attention. Frequently there is a call to drain a large intra-abdominal abscess due to appendicitis, cholecystitis, or other infection. If the incision is made directly thru the muscles, regardless of their direction, an abdominal hernia is almost certain to result. The drainage can be equally thoro if the muscles are split in the direction of their fibers and not divided. Such a wound is rarely followed by hernia. This is not merely theoretical, for I have used this method for many years.

In cases of cancer or tuberculosis it is desired to disclaim any effort to appeal to the esthetic. Here many times the extent of the removal makes for permanent cure or an early relapse. Thoroness of removal of all suspected tissue is the desideratum, regardless of the size of the wound or the ugliness of the resulting scar. After the most extensive resection, when it is possible to cover the gap by a plastic operation, this should be done, but never at the expense of saving tissue that may already be infiltrated with cancer cells.

The special class of cases where nicety in work may be most rationally practiced is in making a clean wound thru clean tissues. To leave the ideal scar requires for first desideratum ab-

solute asepsis. No matter how painstaking the technic may be mechanically, if a stitch-hole abscess or a little suppuration at the margin of the skin occurs, the scar will not be a thing of beauty.

Given perfect asepsis as far as it can be attained and no infection the skin wound should be made with a sharp knife, perfectly clean cut, and with no ragged angles that can not be brought together accurately. The subcutaneous fat and fascia must be cut clearly and nothing left to prevent accurate healing. When the sheathes of the muscles are reached they must be cut as carefully as was the skin. This permits accurate coaptation, which will insure perfect play of the muscle within its sheath without adhesions or danger of hernia of the muscle. The muscles should never be cut, but split. It is practically impossible to cut a muscle and then suture it so accurately that its function will be perfect. Often, when a muscle is cut, the nerve which supplies its motor function is also divided. Its perfect functionating activity would now be prevented by two causes: (1) At the line of division some scar tissue intervenes, making a muscle which formerly contracted perfectly thru its entire length only contract in its two segments separated by the non-functionating scar tissue. (2) The innervation of one or both segments may be greatly impaired by the severance of an important nerve or nerves which supply the motor power.

The next important element contributing to a good scar is perfect hemostasis before attempting to close the wound. A hematoma in the wound, besides inviting infection, retards healing and may defeat the most painstaking efforts for accurate approximation of tissues.

In closing a wound, no matter how carefully made, it is of the utmost importance that the various divided structures should be sutured with anatomical accuracy. The split muscle fibers drop naturally into place when their cut sheaths are sutured, and it must be remembered that if by accident or because of the imprudence of the patient these muscles are made to contract, the split fibers do not separate but are pressed more closely together, whereas if the muscle fibers had been cut, contraction of the muscles would pull the ends wider apart.

The coaptation of the skin margins requires painstaking care. They must be made to fit each other smoothly, without over-lapping and without tension. It is also important in closing such a wound as has been described that no empty spaces be left between the several anatomical layers.

The objectionable skin scars most frequently met may be classified as follows: (1) The broad scar that has stretched, the true skin edges being separated sometimes more than half an inch. (2) The thick cicatricial ridge, often tender and irritable, always unsightly. (3) The scar that forever shows the location of the sutures, due usually to stitch-hole abscess. (4) The puckered scar caused by adhesions of the skin to the underlying structures. (5) The anesthetic scar due to destruction of cutaneous nerves. (6) Painful scars due "either to involvement of nerve-sheaths in the cicatrix, from simple pressure, or from tension consequent upon shrinking of the cicatrix."—(Nancrede.) (7) Finally it is the unsightly scars that are most prone to become ulcerated and to undergo malignant transformation.

The plea for careful avoidance of scars is of most importance when it concerns operations on the face, neck, hands, and arms, but it is of importance everywhere. An esthetic person dislikes to know of any blemish on the skin.

As an indication of what is meant by careful technic, a brief description will be made of a method of operating when the abdominal wall is cut thru, which has proven very satisfactory for a number of years both in avoidance of herniae and of objectionable scars. The skin incision is made a fraction of an inch to one side of the linea alba. The fat and fascia are cut thru to the sheath of the rectus near its inner border. Necessary hemostasis is now accomplished by as many forceps as needed. Next the sheath of the rectus is opened by a cut corresponding to the skin incision, being careful that the point of the knife does not cut the muscles. The handle of the scalpel is now used to split the rectus, only a few fibers being left to the inner side of this slit. The gloved index fingers are often used to lengthen the slit after it has been begun by the handle of the scalpel. Arteries, veins, and nerves are avoided when possible. Now the edges of the wound are separated by retractors, and when free of blood the transversalis fascia and peritoneum are picked up by thumb

forceps and opened with the point of the knife. This wound is then extended to the required size by scissors.

After the intra-abdominal work is completed the wound is closed as follows: (1) Artery forceps grasp the borders of the peritoneum and fascia in sufficient number to give perfect control of the peritoneal wound. (2) A narrow gauze pad wrung out of hot normal salt solution is laid in the abdomen just beneath the peritoneal wound. A tape is always attached, its free end grasped by a strong pair of forceps to avoid all chance of being left behind. This gauze pad prevents the omentum from getting in the way of the sutures, and it is of the greatest importance that no adhesions of omentum be left, as they are likely to cause great abdominal pain. (3) The peritoneal borders are next quickly united by a running suture of plain catgut, removing the gauze pad when the wound has become so short that another stitch will close it. (4) For a three-inch incision two silk-worm-gut sutures are introduced from near the skin margin on one side, thru all the tissues to the peritoneum, but not including it, and out on the other side in the reverse direction. These sutures are not tied now, but are held by an artery forceps on each end. (5) A running suture of about No. 1, 10 day chronic catgut now accurately unites the margins of the wound made thru the sheath of the rectus. (6) A long smooth horse-hair armed with a small sharp-pointed needle next unites the skin margins accurately by means of a button-hole stitch. (7) The silk-worm gut sutures are now tied. They serve the triple purpose of relieving tension on the coaptation sutures, doing away with dead spaces between the anatomical layers, and preventing hemorrhage in the event of the hemostasis not having been perfect. One thing to remember is to tie all sutures just firmly enough to bring the cut tissues into contact without devitalizing them.

This one illustration is only suggestive of what may be done in any region of the body where it is necessary to make a wound, and is much more quickly done than the time it takes to describe it.

If this suggestion on a less vital subject than usual serves to make anyone a little more painstaking in his technic, a little more fastidious concerning the manner in which he makes and closes his wounds, I am satisfied.

On Suppuration in the Temporal Fossa from Disease of the Middle Ear [1]

BY H. GIFFORD, OMAHA, NEBRASKA

I happen to have seen two cases in which pus from the middle ear, instead of following the lines described in most text-books and breaking thru on the outer surface of the mastoid, or into the digastric fossa, has penetrated into the temporal fossa.

One of these patients was a girl of seven years who was sent to me with the history that a month before, the left ear began to pain and discharge. Some days later a swelling appeared above and in front of the ear. This was opened by the family physician, but the history does not state whether he found any pus or not. The swelling continued, however, and during the twenty-four hours before she came to me the lids of that side became edematous. I found a rather anemic girl with the right ear normal, the left ear discharging non-fetid pus thru some part of the drumhead which could not be clearly made out on account of the swelling and adherent epithelium. Between the left ear and the eye the tissues along the zygomatic process were very much swollen, the swelling extending out into the eyelids. There was a small opening in the skin half way between the ear and the eye which was not discharging any pus; deep fluctuation could be felt. Temperature, 103°F. No decided swelling or tenderness over the mastoid. Under chloroform two incisions were made down to the zygomatic process, which was found to be bare, and much pus was evacuated; paracentesis was also made as the posterior part of the drumhead seemed to be bulging. Symptoms improved for ten days, but then the temperature again rose to 103°, and more swelling was apparent above the auricle. Incision here down to the bone evacuated more pus. Two days later the mastoid was opened and pus found in the antrum, but the cells were not involved to any extent; after this the recovery was uneventful except for a peculiar pemphigus-like inflammation of the auricle, which subsided under lead and opium dressing.

[1] Read by invitation at the Denver meeting of the Academy of Otology, Rhinology, and Laryngology, February 16, 1907.

The other patient was a boy whom I saw only at his home and the exact dates of whose affection I can not give. The main facts of his history, however, are as follows: At the age of ten years in the course of an acute attack of inflammation of the left middle ear with the escape of pus from a small perforation in Shrapnell's membrane, he developed a large swelling with tenderness and very slight redness in the preauricular region, which kept increasing slowly with very little pain for several days. I then, altho no fluctuation could be made out, made an incision about an inch in front of the meatus, passing the knife into a depth of about an inch just above the upper margin of the zygomatic process. A few drops of pus escaped, and the swelling gradually subsided and the discharge from the ear ceased. A year later, after catching cold, the left ear began to discharge again thru the old perforation, and in a few days the tissues in front of the ear swelled to twice their ordinary thickness. This time, however, the swelling subsided under the use of hot applications, and the discharge from the ear ceased on the same treatment as that used before, namely, syringing with warm water and the instillation of a mixture of equal parts of saturated boric acid solution and fifteen volumes peroxide of hydrogen. The next winter was passed without any recurrence of ear trouble, but in the succeeding winter, the fourth after the first attack, the same sequence of events occurred. The boy caught cold, the left ear ached a little and then began to discharge thru the opening in Shrapnell's membrane; the preauricular swelling appeared and slowly and steadily increased, until the soft parts seemed to be from two to three times their ordinary thickness. I incised the swelling to the depth of about an inch, but found no pus. The swelling went on with only moderate pain and slight fever for several days more, when I again incised the swelling, this time passing the knife in past the zygomatic process until, at a depth of between two and three inches from the surface, the point struck the bone at the inner side of the temporal fossa. This cut evacuated about a drachm of non-fetid pus, and the symptoms subsided as before. During the five years which followed he had two slight attacks of earache, but by the prompt and vigorous use of hot water in the meatus his mother succeeded in checking the inflammation within a day or two, and since then, by scrupu-

lous attention to the cleansing of the nasal passages and by taking large doses of aconite at the first sign of a cold, he has kept from having any further trouble for about five years; but I have no doubt that if he should allow another otitis media to get well started, he would have a recurrence of the abscess in the temporal fossa.

Before finishing my remarks on this case I wish to state explicitly that at no time did the boy have any pain, tenderness, or swelling behind or above the ear.

Since my first introduction to this complication of middle ear disease, I have kept on the lookout for reports of similar cases in the literature, and have noted only the following:

1. Massier (La Presse Oto-laryngologique Belge, Jan., 1903, Abst. in Archiv. f. Ohrenheilkunde) reports two cases of abscess of the temporal fossa. One of these was of auricular origin.

2. Raoult (Rev. hebdom. de laryngologie, 1902, 42; abst. in Archiv. f. Ohrenheilk.) reports a case of abscess of the temporal fossa in connection with chronic suppuration of the middle ear. A radical operation was performed, but no disease of the mastoid was found; there was, however, a superficial necrosis of the anterior lower wall of the external meatus. The contents of the abscess were fetid.

3. Müller (Fortschritte d. Med., Aug. 1, 1904) reports case of Paul G., nineteen years old; suppuration of the left middle ear after scarlatina; transient tenderness back of ear, then swelling and slight fluctuation in front of ear. Incision found no pus till periosteum of zygomatic process penetrated, then evacuation of 20 ccm. of thick pus; recovery.

4. Antonelli, Recueil d' Ophtalmologie, May, 1905. Girl, age eleven months. Had the grippe, followed by free discharge of pus from the right ear; two days after discharge appeared, tissues in front of ear began to swell, the infiltration progressing steadily forward until the whole zygomatic region and the lids of that side were involved. Antonelli saw the child about two weeks later and found a pasty swelling extending from the ear to the outer commissure of the eyelids. No fluctuation nor pain. After another week Antonelli saw the child again with increased swelling of the side of the face and of the tissues of the upper lid. Fluctuation distinct over the lachrymal gland. An incision along

the margin of the orbit evacuated a caseous mass which Antonelli considered to be the remains of the lachrymal gland, with considerable thick greenish fetid pus. A sound passed along the bare bone to the apex of the orbit. A drain was introduced and the symptoms gradually subsided, tho at the time of Antonelli's report the swelling of the cheek was not entirely gone and the ear was still discharging. No mention is made of any mastoid symptoms. Antonelli thinks the infection passed from the middle ear either thru the Glaserian fissure or the incompletely closed petro-tympanic suture; thence between external pterygoid and the temporal sheath to the pterygo-maxillary fossa; thence thru the spheno-maxillary fissure to the orbit.

In attempting to explain this complication it may be that in cases like the first one in my report, the suppuration has simply spread from the mastoid cells into the cells in the root of the zygomatic process and then has broken thru, either on the outer surface of the process as in Müller's case, or into the temporal fossa. But where mastoid symptoms have been entirely wanting and especially where, as in my second case, the complication has recurred repeatedly, it seems more likely that the zygomatic cells are infected directly from the middle ear, the occurrence being favored by some natural defect in the tympanic wall. We should remember that the zygomatic and squamous cells are originally, and perhaps always, an entirely separate system from the ordinary mastoid cells, sometimes attaining such a development that Schwalbe, in his Anatomie der Sinnesorgane, speaks of the cavity in the root of the zygoma as the antrum squamosum. So far as I know no one has observed direct openings from the tympanum into the zygomatic cells, but Cholewa (Deutsche Med. Woch., 49, 1888) in explaining the occurrence of abscesses above the temporal ridge, cites Zuckerkandle to the effect that out of 200 skulls, he found four with a direct opening from the posterior part of the tympanum into the lowest cells of the squamous portion of the bone, that is, into cells which anatomically belong with the cells in the zygomatic root. It is possible, also, that incomplete closure of the masto-squamosal suture, as observed by Cholewa, may account for some of these cases.

With regard to the path taken by the pus or infection from the zygomatic root to the temporal fossa, most of the cuts which

show these cells depict quite a thick layer of compact bone between the cells and the fossa, but in a plate accompanying an article of Bezold's (Archiv. f. Ohrenheilk. XIII, 1) a section of a temporal bone is shown in which one of the cells in the zygomatic root has only an exceedingly thin wall of bone to separate it from the fossa; and the infrequency with which the latter is involved is a strong indication that these zygomatic cells, on account of their separate anatomical origin, are really but seldom involved in the infection of the real mastoid cells.

There is, of course, the possibility that the infection may have passed thru the Glaserian fissure, and in Antonelli's case this or the incompletely closed petro-tympanic suture may, quite possibly, have been the route taken; but we should expect some marked interference with the action of the jaw if this had been the case with the other patients mentioned, and nothing of the sort was noticed in my cases nor in the others so far as I can determine.

Clinically, this complication is of comparatively benign significance. All the cases apparently have done well with no other treatment than opening the abscess. In the therapeutics, the only point that I wish especially to urge is the necessity of sometimes going very deep in order to reach the abscess. We so seldom have to open abscesses in this region that, speaking from personal experience, I should say that there was a decided tendency for the aurist to get cold feet after having passed the knife in for an inch or so with no results. One can not help picturing the embarrassment which would be felt on cutting an artery at a depth of two or more inches from the surface; but, as the last of my cases showed, it is sometimes impossible to reach the pus without pushing the knife clear past the zygomatic process until it strikes the inner wall of the temporal fossa.

Report on a Clinical Case

BY W. F. MILROY, OMAHA, NEBRASKA

The following case appeared in the clinic at Douglas County Hospital:

HISTORY.—John K., aged 21, American, height 5 feet 8 inches, weight 156 pounds, occupation cook, entered the hospital December 1, 1906. His family history was negative. He has never used alcoholic liquors except occasionally a glass of beer. For two or three months each spring, from the time he was a young child until he was thirteen years old, he suffered with diarrhea, being well the remainder of each year. When thirteen years old he was in bed four months with diarrhea. Eight or ten times during this attack he passed a little blood mixed with mucus from the bowel. After this attack he had similar ones of mild character, becoming less severe each summer. This trouble has not recurred since 1903.

In 1902 the patient had his body severely squeezed between two cars, and immediately vomited about a teacupful of blood. There was no other blood passed at that time.

In the spring of 1905 he was very sick for two weeks with malaria. He worked the following summer, but was not strong. In the fall the malaria recurred twice, but was controlled by quinine. Later, having discovered a tumor in his abdomen, he was told by a physician that this was his spleen. With each recurrence of the malaria this tumor was swollen and tender, these symptoms subsiding when he recovered. Last spring he removed from St. Louis to central Illinois. Here he worked as a teamster, and all trouble from the spleen disappeared tho the tumor remained. He ate well, took no medicine, and felt strong, and in every way well, and was about his maximum weight until August.

At about 8:00 P.M., August 5 last, the patient fell, his abdomen striking heavily across the edge of a board. He felt sick and faint and went to bed. He had a good night and felt well next morning. At breakfast he felt nauseated and began to vomit blood. The first was dark and clotted; afterward it was bright red. He also passed blood from the bowel. He was put to bed unconscious, where he remained two weeks. No further hem-

orrhage occurred. He was again at work in one month. A week later he had a malarial attack lasting two days, the spleen being swollen and sore again. He worked steadily until November 29, when he felt the malarial symptoms and left off work, but did not go to bed. On November 30, while standing in the street, he discovered blood running from his bowel, he being unable to control it. The quantity he estimated at eight ounces. He vomited none, but the next stool contained blood. He has never had a hemorrhage except upon the above occasions. He has always had excellent digestion except when the diarrhea was present. He has never been jaundiced.

PHYSICAL EXAMINATION.—Lungs normal. A well-marked and widely distributed mitral systolic murmur with strongly accentuated pulmonic second sound was present. Left border of the heart nearly one inch to the left of the mid-clavicular line and the right border one inch to the right of the right sternal line. Liver apparently about normal in size. Tenderness in the left hypochondriac region. The spleen reaches from the seventh rib to within two finger breadths of the level of the umbilicus and as far as the left parasternal line.

There was a moderate amount of ascites, but no other dropsy.

URINARY EXAMINATION.—Negative.

DIAGNOSIS.—Trauma, cancer, peptic ulcer, and decompensated valvular lesion are readily eliminated. Altho the malarial organism has not been found in repeated blood examinations, it can hardly be doubted that the patient has had that disease. However, the first hemorrhage occurred three years before the patient contracted malaria. The exsanguinating hemorrhage of August 5 took place when the patient was in the best of health, and ascites is not caused by malaria under conditions like the present.

Admitting the presence of the disease, it is inadequate to account for all of the phenomena present. Tubercular peritonitis is suggested by the history of the prolonged intestinal trouble and ascites. The following considerations negative this theory: 1st, the good general nutrition of the patient; 2d, the healthy condition of the lungs; 3d, the patient recovered from the diarrheal trouble; 4th, he has no fever; 5th, peritoneal exudate, if inflammatory, has a specific gravity of 1018 or more and contains albumen, 4.5 per cent or more. If not inflammatory, it has a specific gravity of 1015 or less, and contains albumen, 2.5 per

cent or less. Sixty ounces of fluid were withdrawn from this patient's abdomen. It had a specific gravity of 1009, and contained albumen .08 per cent.

"Splenic anemia," so-called, is scarcely regarded as a pathological entity. It is an obscure condition about which we know little. In this disease the spleen is greatly enlarged, firm, smooth, and usually tender. The enlargement is usually progressive. There is no other glandular enlargement. There is progressive dyspnea and muscular weakness very much as in pernicious anemia. Hemorrhages from the gastro-intestinal tract, repeated at intervals, are characteristic. Between these attacks the health may be good. When the disease has existed for a long while the liver may show a secondary cirrhosis. This is the condition known as "Banti's disease." Hemorrhage often occurs before any change has taken place in the liver and is due apparently to mechanical obstruction of the venous circulation of the stomach in those areas which are drained by the splenic vein. Ascites may be present. Briefly stated, the anemia is of the same type as that usually considered to be characteristic of chlorosis.

The following report by Dr. Bliss indicates the condition of the blood at the first examination after the patient entered the hospital:

Blood examination of J. K., Douglas County Hospital.
Red blood corpuscles 2,120,000.
White blood corpuscles 4,000.
Hemoglobin content 40 per cent.
Color index 1 minus.
Polymorphonuclears 70 per cent.
Small lymphocytes 23 per cent.
Large lymphocytes 4 per cent.
Large mononuclears none.
Transition cells 2 per cent.
Eosinophiles 1 per cent.
Some poikilocytosis. No nucleated reds. No plasmodia malariae.

In juxtaposition to this disease let us place atrophic cirrhosis of the liver. Atrophic cirrhosis of the liver occurs with a history of alcoholism in only 50 per cent of the cases. So long as the collateral circulation compensates for the obstruction to the portal circulation caused by the contracting connective tissue, the disease may be latent. Frequently hemorrhage is the first symp-

tom observed. The first hemorrhage may be fatal. Dropsy, appearing first in the peritoneum should always suggest portal obstruction. I have already shown that in the present case this effusion was non-inflammatory. Jaundice is absent. The liver, early, is normal in size, enlarged, or slightly diminished. The spleen is usually enlarged and palpable. The disease may be caused by malaria.

Hematemesis and ascites may both occur (*a*) in splenic anemia in the absence of cirrhosis; (*b*) in splenic anemia with cirrhosis (Banti's disease); or (*c*) in atrophic cirrhosis of the liver. The blood findings do not establish the diagnosis. One would not expect to find so great a degree of enlargement and tenderness of the spleen dependent upon the ordinary cirrhotic liver, unaccompanied by more widely distributed and conspicuous signs of portal obstruction; but if to that liver disease malaria is added the phenomena observed would seem to be all accounted for in a rational manner. As a general proposition, it is always wise in diagnosis to accept the probable rather than the possible, the usual rather than the rare occurrence. In the present case, I incline to the theory of cirrhosis of the liver with malaria rather than the theory of the splenic anemia with malaria.

Splenectomy was performed upon this patient, by Dr. J. E. Summers, Jr., on March 1, 1907. This course was decided upon in consideration of the gloomy outlook before the patient should medicinal treatment be continued, for his condition had not materially improved during the three months since his admission to the hospital. Furthermore, the patient had become very despondent and anxious to undertake any treatment offering a hope of improvement.

The patient rallied well from the immediate effects of the operation. For six days his condition appeared to be excellent. On the seventh day an acute entero-colitis developed, complicated by signs indicating perforating appendicitis. The abdomen was opened. The appendix was found to be normal, but the entire colon was in a most remarkably edematous condition, with perforations at the sigmoid flexure *at the mesenteric border.* The perforations were closed by suture and omental grafts and pelvic and iliac drainage employed.

At present, March 22, the patient is in good condition, apparently having a fair prospect of recovery.

THE BULLETIN

OF THE

UNIVERSITY OF NEBRASKA

COLLEGE OF MEDICINE

HENRY B. WARD, Dean, Lincoln HAROLD GIFFORD, Associate Dean, Omaha

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EDITORIAL

A recent report of the Pennsylvania State Board of Medical Examiners stated that about 50 per cent of the candidates failed in the fundamental branches, and that a very large number of those who passed succeeded in doing so only by reason of the high marks attained in the so-called practical branches. They said, "The matter is so serious, as is self-evident, and has prevailed without any practical variation ever since the Practice Act has been in force, that it demands serious investigation." It is probably true that the fault of which this State Board of Medical Examiners complains is a fault primarily of the students' attitude toward the foundation stones of his professional knowledge. The medical student is preeminently utilitarian in his philosophy. Breathing the atmosphere of the practical studies and affiliating with more advanced students engaged in this work, it is almost inevitable that the student of the earlier years shall dissipate his time by giving attention to the more enticing practical subjects, to the serious detriment of thoroness in his own proper work. We believe that the arrangement of this institution, which wholly

separates the work of the junior and senior years from the scientific studies that should precede it, possesses a very material advantage. By this scheme the temptation to slight the foundation studies is removed, and the Pennsylvania Board will find graduates of the University of Nebraska equally strong all along the line. We commend to them our plan as a solution of their difficulty.

While it is possibly true that the unity of the several parts of this college is not so evident to the casual observer as in the case of the university whose buildings all stand within a single enclosure, yet its unity is none the less real, since its courses are adjusted to that end. Passing from the work in Lincoln to that in Omaha, the student discovers that he is not entering another institution, but by natural advancement is pursuing an uninterrupted course toward his degree. The present number of the BULLETIN emphasizes the clinical side of the course. The facilities at the disposal of the College for accomplishing this important part of the physician's training are set forth, at some length, in the accompanying supplement. We believe they will commend themselves as being in harmony with the degree of excellence maintained in other departments of the University.

COLLEGE NOTES

Mr. Chas. Lieber, class of 1908, paid a flying visit to Lincoln recently.

Dr. C. A. Hull of Omaha made a hurried trip to Colorado on March 23.

Dr. P. Dempster, class of 1904, has recently located at Granger, Washington.

Mr. John Allen went to Philadelphia on business at the end of the semester.

Dr. W. O. Bridges recently took a few weeks' recreation by traveling through Cuba.

Dwight E. Wilson, a freshman last year in the six-year medical course, visited Lincoln.

Dr. J. W. Straight, class 1891, has gone into practice with Dr. F. S. Taylor in Hastings.

Dr. S. G. Allen, class of 1901, was elected one of the board of censors of the Colfax Medical Society.

Dr. Andrew P. Overgaard, of Fremont, was elected secretary of the Dodge County Medical Society.

Dr. F. S. Owen spent a few days hunting in Minnesota and reports a delightful time and much game.

Dr. E. S. Empey of Papillion, class 1905, who had practiced in Scotts Bluff, died January 28 of tuberculosis.

Dr. Chas. D. Eby, class of 1904, of Leigh, Nebraska, was recently elected vice-president of the Colfax Medical Society.

Dr. Lauzer, until recently assistant surgeon of the Pacific Coal Co. at Cumberland, has located at Rock Springs, Wyoming.

Dr. Hector MacArthur, class 1904, has been appointed assistant surgeon for the Union Pacific Coal Co. at Hanna, Wyoming.

The resignation of Prof. Paul Koerber, instructor in materia medica and therapeutics, was accepted by the Board of Regents.

Mr. J. J. Fossler and Mr. C. Stein, class 1907, have accepted positions as internes at the Immanuel Hospital for the ensuing year.

Dr. R. C. Nelson, class '01, was a visitor February 26. He was in search of an assistant in his large practice at Lead, South Dakota.

Drs. Aikin and Bridges gave short talks on medical fees before the Dodge County Medical Society at Fremont, March 14, by request.

Max Koetter, M. D., University of Nebraska College of Medicine 1903, died at Burlington, Wyoming, quite suddenly February 22, aged 28.

Dr. and Mrs. B. B. Davis recently took a trip to Florida and Cuba. They were gone about three weeks and reported a very pleasant time.

Mr. J. F. Allen and Mr. C. H. Willis, class 1907, have been appointed resident internes at the Methodist Hospital, for the year beginning June 1.

At the January meeting of the Elkhorn Valley Medical Society Dr. D. W. Beattie of Neligh, class of 1897, was elected president for the ensuing year.

A bill has been introduced into the legislature establishing a state health laboratory under the direction of the State Board of Health and the University.

Mr. M. B. Wyatt and Mr. C. S. Stoakes, senior students, took the competitive examination for interne appointments at the Douglas County Hospital March 23.

A beautiful saccular aneurism, involving the ascending and transverse arches of the aorta, was recently posted and added to the collection in the rapidly growing Museum.

Drs. O. Chambers and J. H. Young, class of 1903, formerly of Cumberland, Wyoming, have been appointed chief surgeons of the Union Pacific at Rock Springs, Wyoming.

The chemical laboratories in Omaha have recently been supplied with a Stanton modification of the Riva-Rocci blood-pressure apparatus, an apparatus for frozen sections, and more immersion lenses.

The BULLETIN is under obligation to Dr. A. R. Knode, class of '04, for the addresses of half a dozen alumni of the medical college whom it has been impossible to reach in the past.

Dr. H. D. Singer, assistant superintendent of the Norfolk Hospital for the Insane, is delivering the course of lectures on mental diseases in the College of Medicine in Omaha this semester.

The Junior class met February 6, 1907, and elected the following officers: J. B. Grinnell, president; Josiah Kerr, vice-president; Miss Ada Platz, secretary; S. L. Taylor, treasurer; L. T. Sidwell, sergeant-at-arms.

Captain Rhoads of the United States army, who has been occupying the chair of medical sanitation and tropical diseases, has been relieved by Col. John M. Bannister, chief surgeon of the Department of the Missouri.

It is reported that Dr. A. Johnson, class of 1890, has announced his intention of resigning his position as superintendent of the Feeble Minded Institute at Beatrice. We hope his successor will be equally successful in his management of this deserving institution.

A vital question before the student body of the College of Medicine is the representation of the College in the *Cornhusker* by a managing editorship. The Senior class has granted such representation, but at the time the BULLETIN goes to press it still remains an open question with the juniors.

The banquet of Iota chapter Phi Rhos at the Chesapeake, March 22, was a great success, about sixty participating. Dr. A. Hugh Ferguson of Chicago was the guest of honor who made the principal address. Drs. Ward, Christie, and Owen responded to toasts. Mr. E. M. Ware as toastmaster was equal to the occasion, and sustained the reputation of his predecessors.

Prof. Charles S. Minot, of the Harvard Medical School, visited the University of Nebraska and delivered an address before the medical faculty and students on the new ideals of medical education for which the new laboratories of the Harvard Medical School stand. He also delivered before the Sigma Xi Society an address on the "Biological Interpretation of Life."

The speakers before the Pathological Society during the last three months were Dr. Ward on January 31 and Dr. Mayhew on February 28. Dr. Ward's paper was his vice-presidential address before the A. A. A. S., "The Influence of Parasitism on the Host." Dr. Lord of Omaha was the guest of the evening. Dr. Mayhew's paper, "The Chloride Reduction Treatment in the Nephritis of Arterio-sclerosis," was of interest.

The nineteenth semi-annual meeting of the Missouri Valley Medical Society, which was held in Omaha, March 21 and 22, was one of the best in its history. Lectures at the College were discontinued during the afternoon of the 21st that the seniors might be privileged to attend. Chairman Dr. W. F. Milroy called the meeting to order at 1:30 P.M. Thursday. Drs. Crofton, Turck, and Ferguson of Chicago read papers, as did also Sloan and Hall of Kansas City and Knott of Sioux City. Dr. Harold Gifford and Dr. S. R. Towne of the faculty each read very interesting papers. The smoker and vaudeville given by the Douglas County Medical Society on Thursday evening was most enjoyable.

Saturday, March 23, was Lincoln clinic day at the various hospitals in Omaha. An appreciative delegation from the University city came up on Friday in which we noted Krake, Cutter, Sayer, Buol, Mantor, Hickman, Waddell, Reed, Olsson, Anderson, Fordyce, Scott, Stearns, Osborn, Tatsukawa, and Wyatt. They were divided into sections taken in charge by committees of the Junior class, and escorted to the County, Methodist, Immanuel, Wise Memorial hospitals, and the Child Savings Institute, where clinics were held by Drs. Aikin, Bridges, Davis, Gifford, Owen, and McClanahan. A luncheon at the Calumet followed, reuniting the Omaha and Lincoln students in the bond of convivial fellowship. Dean Ward and Drs. Guenther and Willard of Lincoln accompanied the students.

The Medical Society of the University continues to manifest numerous symptoms of activity which, considering the little leisure time students have, is most commendable. The second semester election of officers of the society resulted in Mr. J. H. Sayer's reaching the presidential chair, with Mr. C. A. Neumann as vice-president. Mr. A. T. Osborn was made secretary; Mr. S. A. Swenson, treasurer; Mr. R. C. Christie, sergeant-at-arms; Mr. C. F. Charlton and Mr. I. S. Cutter, members of the program committee. On February 23 Dr. Poynter spoke on the advisability of certain surgical procedures on the prostate. On March 9 Dr. Lyman discussed in a most interesting manner the subject "Is the Medical Profession Overcrowded?" On April 3 the Society will have the pleasure of listening to Dr. Bicknell of Omaha. His subject as announced is, "Pasteur and Modern Medicine." It is expected that Dr. Schalek will be present with demonstrations. April 17 has been set aside for Dr. Harry Everett of Lincoln. Social functions in the form of a dance and a smoker are contemplated for the near future. Messrs. Krake and Stewart have the latter in hand.

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